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ABSTRACT

This guide was developed by the Portland (Oregon) Public Schools to assist district administrators and teachers, grades 9-12, to comply with federal and state mandates to develop and implement a plan for alcohol and other drug prevention instruction. The guide is based on the district-adopted curriculum, "Here's Looking at You, 2000," which includes instruction in three domains: cognitive/information, affective/bonding, and behavioral/skills. Included in the guide is a high school planning matrix and a topic summary, with content areas (physical education, social studies, science, and health) for each topic identified. Recommended learning outcomes are outlined for health education, physical education, social studies, science, and special education. For each content area, additional resources are suggested. The appendices include: the Oregon Administrative Rule which mandates implementation of alcohol and other drug use prevention instruction; a paper, "Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention"; and a reprinted article, "Knowing What To Do--and Not To Do--Reinvigorates Drug Education." (IAH)

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PORTLAND PUBLIC SCHOOLS

ALCOHOL AND OTHER DRUGS

CURRICULUM IMPLEMENTATION

PLANNING GUIDE

GRADES 9 - 12

FEBRUARY 1992

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INTRODUCTION

State and federal laws mandate the development of a plan for alcohol and drug prevention instruction for grades 9-12. This guide is intended to assist high school administrators and teachers with planning and implementation in meeting the mandates.

Those who assisted with development of the guide are:

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OVERVIEW OF STATE AND FEDERAL LEGISLATION

Oregon law now requires each school district to develop a plan for drug and alcohol prevention instruction as an integral part of the district's health education program.

The Oregon Administrative Rule (OAR) provides that this instruction must emphasize prevention, it must be reviewed and updated annually to reflect current research, and it must be consistent with State Board adopted Health Education Common Curriculum Goals. The rule lists various types of basic information which must be provided, including promotion of health and wellness, the health and legal implications of drug use, and the availability of school and community resources.

In addition, the OAR provides that the instructional program must include activities which will assist students in developing and reinforcing skills to understand and manage peer pressure, understand the consequences of consuming alcohol and other drugs, and to make informed and responsible decisions. The program must include activities which will motivate students to adopt positive attitudes toward health and wellness.

In 1989, the Congress revised the Drug Free Schools and Communities Act. Under that Act, regulations were established which, though cast in somewhat different terms, cover essentially the same points as the Oregon rule. Minor differences include the federal regulations' specific mention of anabolic steroids as included within the coverage of the regulations and the federal requirement of biennial, rather than annual, review of the plans.

RECOMMENDATIONS OF THE COMMITTEE

Early Prevention Efforts

As teachers reviewed the literature, they became aware that the field of alcohol and other drug prevention education has made great strides since the 'sixties, when illicit drug use by many groups, including minors, increased dramatically. Early prevention education was not research-based and it was not effective in reducing drug use. These well-intentioned efforts often utilized scare tactics including the use of recovering addicts as speakers. Inaccurate information about drugs was often presented. In too many instances these efforts had the paradoxical effect of increasing interest in, and subsequent use of, alcohol and other drugs. Later approaches addressed student attitudes about themselves and external pressures from peers and the media. Again, drug use was not reduced.

Current Prevention Research

Recent work by David Hawkins and colleagues on risk factors for adolescent substance abuse provides a research base for prevention curriculum. In the District-adopted program *Here's Looking at You, 2000*, one or more of these risk factors is addressed in each lesson. This curriculum recognizes that an important risk factor is family chemical dependency. Increased understanding of the disease concept of chemical dependency, its genetic aspect, and the psychosocial effects on the family give students sensitivity to these issues in general, and, in the case of children living in chemically affected families, a perspective that is useful to them in addressing family issues.

The current literature shows that information alone does not reduce drug use and that information in conjunction with affective learning does not have significant impact unless it is combined with social skills training. These skills address the strong peer influences which impact drug use by adolescent and high school students. Instruction in friendship and resistance/refusal skills provide students with understanding and strategies to implement a variety of healthy choices.

Effective Curriculum: Content

Effective curriculum includes straightforward, up-to-date information on alcohol and other drugs, with emphasis on the gateway drugs: tobacco, alcohol and marijuana. Recently the U. S. Office of Substance Abuse Prevention declared crack a gateway drug in inner cities. Whether this applies to Portland youth is not clear, but in some schools it would be wise to include this topic without slighting alcohol, tobacco, and marijuana.

Many teachers are including lessons on self esteem, self awareness, stress management, and friendship development in comprehensive health education instruction. These lessons are also important in prevention of later alcohol and other drug use.

Effective Curriculum: Teaching Strategies

Teaching methods are found to be as important as content in prevention education. Appropriate strategies to involve students, cause them to reflect on their own attitudes, and to interact with others in ways in which the needed skills can be practiced. Open-ended discussions improve listening skills and expose children to various points of view in a non-judgmental setting. Cooperative learning strategies, including role play, simulation, and other shared learning activities are especially effective. Selection of appropriate content and strategies is essential if the desired behavior change is to take place.

Summary

In summary, effective prevention education not only meets the letter of the law, but also meets the needs of students. The curriculum should:

1) address the three domains of learning:

- cognitive - information
- affective/attitude - bonding
- behavioral - skills

2) utilize appropriate, effective teaching strategies;

3) include a clear "no use" message;

4) allocate sufficient time for optimum results.

IMPLEMENTATION

High School Planning Matrix

Since it is the responsibility of each high school to provide AOD prevention education every year, we have included this high school planning matrix to assist each building in determining where AOD content will be addressed. There is a Topic Summary for high school on pages 10 and 11 outlining AOD topics which can be addressed in each subject area.

Grade	HEALTH	PHYSICAL EDUCATION	SCIENCE	SOCIAL STUDIES	OTHER	D&A COUNSELOR
9						D&A Counselor can assist in these ways:
10						• providing technical information
11						• networking • organizing awareness day/ week activities
12						• co-leading discussions on a specific topic with a classroom teacher

For Your High School:

1. Place an "X" in space(s) where required Health is taught.
2. Determine departments/courses in which AOD content is currently addressed or will be addressed in non-Health classes to comply with the OAR.
3. Remember that AOD content is to be addressed each year of a student's four-year high school experience.
4. Please ensure that Special Education and ESL students are receiving instruction either in the mainstream or in their pull-out classes.
5. Due to scheduling and individual school differences, if you have a year that AOD content is not included in Health, Science, Social Studies, or Physical Education, a specific group of students (for example, seniors) may address the AOD topics in one of several ways: AOD speakers forum, assembly presentations by a theater group, awareness day, etc.

AOD Topic Summary: High School

	AOD RELATED INFORMATION	HLTH	SCI	SS	PE
I.01	Health and Wellness	•			•
I.02	Definition of a drug	•	•		
I.03	Drugs and their effects	•	•		•
I.04	Dangers of unknown substances	See Elementary Topic Summary			
I.05	Chemical dependency: individual/family	•	•		
I.06	Alcohol	•	•		
I.07	Tobacco/secondhand smoke	•	•	•	
I.08	Marijuana	•	•		
I.09	Cocaine	•	•		
I.10	Other drugs	•	•		•
I.11	Look alike stimulants	•	•		
I.12	Factors which influence effects AOD	•	•	•	
I.13	AOD affected children	•	•		
I.14	Relationship AOD use and disease	•	•		
I.15	AOD abuser hurting others	•			
I.16	Driving and AOD	•	•		
I.17	AOD-related emergencies/911	•			
I.18	Reasons why people use/don't use AOD	•			•
I.19	Risk factors and ways to reduce them	•			
I.20	Ident./evaluation of information: AOD		•		
I.21	AOD advertisements	•	•		
I.22	AOD causing problems: future and present	•			
I.23	Non-stereotypical description AOD users			•	
I.24	Sexuality and AOD	•			
I.25	Early warnings of AOD abuse	•			
I.26	Action on AOD related issues	•			•
I.27	Norms/values: family, cultural, societal			•	
I.28	Healthy alternatives to AOD use	•			•
I.29	Selection of friends, groups	•			•
I.30	Rules, laws relating to AOD use	•		•	•
I.31	AOD resources: school/distr./community	•			

	AOD RELATED SKILLS	HLTH	SCI	SS	PE
	Communication Skills				
S.01	Assertiveness:←Asking for things	•			
S.02	Resistance/refusal skills	•			
S.03	Friendships and relationships	•			•
S.04	Listening skills/open ended discussion	•	•		
	Decision Making/Problem Solving				
S.05	Decision Making	•	•		•
S.06	Sources of pressure/influence	•	•		•
S.07	Goal setting	•	•		•
S.08	Healthy choices	•			•
	Self Awareness Skills				
S.09	Self control (Keeping out of trouble)	•		•	•
	SPECIAL AOD SKILLS				
S.10	Prevention of enabling behaviors	•			
S.11	Needs of others for referral	•			
S.12	Referrals procedures	•			
	AOD RELATED ATTITUDES/BONDING				
	• Self-Awareness	These topics are covered in the comprehensive health education curriculum. They are also essential to effective prevention education.			
	• Self-Esteem				
	• Stress Management				
	• Friendship Development				

HEALTH RECOMMENDATIONS

AOD Prevention Education in Health

Because of the importance of this topic for high school students, a major emphasis in a high school Health course is needed. This content will be covered not only in a major unit, but addressed as it applies in Stressor/Risk Management, Life Cycle, Safe Living, and other topics.

Applicable Health Courses

The course in Health in which students can meet the state and federal requirements is Health 1-2. The appropriate Learning Outcomes from three of the five Health Strands described in the planned course statement are listed on the following pages.

Curriculum in Current Use

Here's Looking At You, 2000 continues to be one of our primary resources for drug prevention. The District-adopted program meets the criteria for effective prevention. This program covers most of the needed content for this subject, and more importantly utilizes effective teaching strategies. All three domains of learning are utilized, with lessons on information, self esteem and attitudes (bonding), and development of social skills. This psychosocial model is currently recognized as the most effective model of prevention education. All lessons address one or more of the risk factors for substance abuse by adolescents and young adults.

Teachers who choose to use other materials must demonstrate that the alternative materials not only address the topics but utilize the teaching strategies addressing the three domains of learning: cognitive (information), affective (attitude), and behavioral (skills). For more information on the prevention model, note the article by Bonnie Benard and the "Criteria for Selection of Prevention Education" in the appendix.

Minimum Lessons from HLAY 2000	Lesson Title
3	Guidelines
6	Mother Drinks, Fetus Drinks
7	Beauty and the Beast
8	Secondhand Smoke
11-12	Natural Highs (Day 1 and 2)
13	The Most Addictive Drug
17	Killer on the Road
19	Signs of the Times
20	Living with Chemical Dependency
21	The Family Tree
25	Scenes From a Life
26	Recovering
27	Enabling and Intervention
28	Knowing Your Limits
31	What We Learned
Resistance/refusal skills	Emphasize as needed
Communication skills	Emphasize as needed
Self esteem	Emphasize as needed

LEARNING OUTCOMES:

Ann Shelton, Health Curriculum Specialist, reviewed the Learning Outcomes for Health 1-2 from the five Health Strands for the school district. This list (with Common Curriculum Goals [CCG] noted), which represents outcomes from three of the strands, was then approved by the Health Department Chairpersons as suitable for AOD instruction.

HEALTH 1-2 Learning Outcomes

Stressor/Risk Management Strand

SM9	Discuss positive and negative methods of dealing with stressors.	CCG* 2.1D, 2.1F, 3.1G
SM10	Practice coping skills such as prioritizing, organizing, assertiveness skills and refusal skills.	CCG 2.1C, 3.1G
SM15	Investigate community resources available for stress reduction, crisis intervention, and emotional and psychological illness.	CCG 2.1C, 2.1G

Effective teaching of refusal and communication skills and self-esteem will occur when lessons are addressed in all three domains of learning: Cognitive (knowledge), but in particular Affective (bonding) and Behavioral (skills).

* Health Common Curriculum Goals, 1987, State of Oregon.

Life Cycle Strand

L3	Describe the positive effect of healthful nutrition, regular medical supervision, exercise and rest, and the negative impact of external influences (drugs, alcohol, x-ray, smoking) on the developing embryo/fetus.	CCG* 1.1A, 1.1B, 1.1E, 1.1F, 1.1K
L8	Know that it is OK to say "no."	CCG 1.1C, 1.1G
L9	Recognize the importance of continuing to develop positive self-concept, decision-making skills, refusal skills, and short- and long-term goal setting.	CCG 1.1C
L10	Understand that adolescence is a unique life stage, both physically and emotionally.	CCG 1.1B
L11	Realize that mature, responsible decisions and behavior during adolescent years lead to broader opportunities for a fulfilling life in the years ahead.	CCG 1.1A, 1.1C, 1.1K
L12	Practice skills that strengthen relationships and improve communication.	CCG 1.1C
L14	Describe situations in which adolescents practice responsibility for their own actions.	CCG 1.1A, 1.1B, 1.1C, 1.1D
L18	Be aware of alternative lifestyles.	CCG 1.1E, 1.1F
L24	Know that the health behaviors practiced today greatly influence a person's physical and mental health throughout the later stages of the lifespan.	CCG 1.1B, 1.1H, 1.1K, 3.1G, 4.1J

Safe Living Strand

SL1	List and describe hazardous and life threatening situations.	CCG 1.1A, 1.1B, 1.1E, 1.1F, 1.1K, 2.1A, 4.1E
SL2	Identify unsafe practices in his/her life.	CCG 1.1A, 1.1B, 1.1E, 1.1F, 2.1A, 4.1E
SL3	Develop a plan to modify/eliminate unsafe practices.	CCG 1.1C, 1.1D, 1.1F, 1.1H, 1.1I, 1.1K, 2.1C, 2.1H, 4.1E
SL4	Perform basic first aid skills in emergency situations.	CCG 1.1G
SL6	Describe Oregon laws regarding use of safety belts, driving under the influence of intoxicants, and minor-in-possession.	CCG 1.1B, 1.1C, 1.1E, 1.1I

* Health Common Curriculum Goals, 1987, State of Oregon.

SL7	Recognize indications of pending crises in the life of self or others where coping skills and resources may be adequate.	CCG* 1.1B, 1.1D, 1.1E, 1.1F, 2.1A, 2.1F
SL8	Analyze why risk-taking behaviors are stressors that need to be addressed.	CCG 1.1B, 1.1E, 2.1B
SL9	Be familiar with the causes, characteristics, and preventive measures related to destructive behaviors such as running away, suicide, eating disorders, and substance abuse.	CCG 1.1B, 1.1E, 1.1F, 1.1K, 2.1A
SL10	Examine the influence of cultural patterns, genetics and natural environment on types and incidence of destructive behavior.	CCG 1.1B, 1.1D, 1.1E, 1.1F, 1.1K, 2.1B, 2.1D
SL11	Demonstrate healthful crisis intervention skills, including how to deal with a person who has suicidal tendencies.	CCG 1.1G
SL12	Identify community resources that deal with and treat adolescents with problems.	CCG 1.1A, 1.1B, 1.1F, 1.1I, 2.1G
SL13	Describe prevention, transmission, symptoms, treatment, and risks of sexually transmitted diseases, including AIDS, and other prevalent communicable diseases, such as hepatitis.	CCG 1.1E, 1.1F, 1.1K, 2.1A
SL15	Design a personal plan for chronic disease prevention or early identification.	CCG 1.1D, 1.1F, 1.1H, 1.1K, 2.1C
SL16	Recognize that present lifestyle directly influences one's future health and longevity.	CCG 1.1A, 1.1B, 1.1C, 1.1E, 1.1F, 1.1K, 2.1B, 2.1E, 3.1G, 4.1D, 4.1J

* Health Common Curriculum Goals, 1987, State of Oregon.

Health Resources for AOD Instruction

Curriculum Infusion Lessons

- *AOD High School Infusion.* Oregon Department of Education. 1990.
- *Education for Self-Responsibility II: Prevention of Drug Use.* Texas Education Agency. 1989
- *P.A.C.T. Project (Peer Assistance Curriculum and Training).* University of California. 1988.
- *Project EDAHOE (Enacting Drug Abuse Prevention Through Higher Opportunities in Education).* Lewis-Clark State College. 1991.

Other

Available from Sue Rowe, Curriculum Development and Services, 280-5840 ext. 474.

- *Here's Looking At You, 2000* kits available on a check out basis from Alcohol and Drug Office, Student Services Department, Child Services Center; on-site training if interested. Every high school has a kit in its building.
- *Parents On Your Side* by Lee and Marlene Canter. This is a 5-credit video course, a comprehensive parent involvement program for teachers. Other classes are *Assertive Discipline* and *Homework Without Tears.* For information write: Lee Canter & Associates, P.O. Box 2113, Santa Monica, CA 90407-2113.
- *Preventing Drug Affected Babies* packet of materials compiled by Bob Olds and Mary Ellen Marmaduke soon to be printed and made available.
- Western Center for Drug Free Schools and Communities — drug prevention curricula, audio-visuals, and technical articles available. Contact Sue Rowe, Curriculum Development and Services, 280-5840 ext. 474.

PHYSICAL EDUCATION RECOMMENDATIONS

Why Infuse AOD Content in Physical Education Courses

The Physical Education teachers who worked on the AOD Curriculum Project during the summer of 1990 and 1991 explored ways in which this topic could be infused in P.E. classes, especially freshman P.E. They believe this content is an important part of basic physical education and provides continuity on this topic with other disciplines.

Applicable High School P.E. Course: P.E. 1-2

Appropriate Course Goals from Physical Education 1-2 courses were selected by John Hinds, Physical Education Curriculum Specialist, and approved by members of the committee. They are listed on the following pages, with Common Curriculum Goals (CCG) noted.

Proposed New Materials

Many P.E. teachers are including AOD content in their classes, but there has not been consistent content and strategies throughout the district. The P.E. teachers on the committee felt that P. E. 1-2 would be an appropriate place for primary lessons on two issues: use/abuse of anabolic steroids, and Portland Public Schools regulations in compliance with Oregon laws relating to student possession, sale and use of alcohol and other drugs.

Primary Lessons

- Alcohol and Other Drugs: School District Regulations, Oregon Laws
- Use/Abuse of Anabolic Steroids

Optional Lessons

Additional P.E. lessons for AOD infusion are available from the following sources. Contact Sue Rowe, Curriculum Development and Services, 280-5840 ext. 474.

- *Education for Self-Responsibility II: Prevention of Drug Use.* Texas Education Agency, 1989.
- *P.A.C.T. Project (Peer Assistance Curriculum and Training).* University of California, 1988.
- *Project EDAHOE (Enacting Drug Abuse Prevention Through Higher Opportunities in Education).* Lewis-Clark State College, 1991.

PHYSICAL EDUCATION 1-2:

Awareness (Concept I)

The student values physical and mental wellness for self, family, associates and society.	CCG* 2.3A
The student knows and values the structure and functions of the human body.	CCG 2.1C
The student is able to apply health and safety practices when participating in physical activity.	CCG 3.2E
The student values the personal qualities of self-control, self-confidence, and respect for others.	CCG 3.2E
The student knows that the values received from physical activity is directly related to the effort and energy expended.	CCG 2.1A
The student values striving to achieve within personal abilities and limitations.	CCG 2.1B

Cooperation (Concept II)

The student follows rules in all areas of participation.	CCG 1.3A
The student knows that individuals can contribute to team morale (e.g., tolerance, encouragement, respect for others, cooperation).	CCG 2.3B
The student knows that putting undivided contributions together into a team effort requires honesty, loyalty, cooperation and self-discipline.	CCG 2.3C, 3.3F
The student knows the values that can be achieved through participation in a team effort (e.g, following accepted codes of ethics, loyalty and consideration).	CCG 1.3C

Physical Well Being (Concept IV)

The student uses a healthy environment in which to participate in physical activity.	CCG 3.1H, 3.2B

* Physical Education Common Curriculum Goals, 1988, State of Oregon.

Fitness (Concept V)

The student knows that the benefits of fitness include reduced health risks, greater productivity at work or play, and increased quality of life.	CCG* 2.1A, 2.3A
The student knows nutrition and exercise factors that help build and maintain strong, healthy bone structure throughout life.	CCG 2.3A
The student knows the values in maintaining an efficient fitness level (e.g., life-long, efficient body growth and development).	CCG 2.2B

Environment (Concept VI)

The student knows ways by which one's environment affects physical fitness (e.g, community, home, place of work, school).	CCG 3.2B

Disabilities (Concept VII)

The student knows that when normal functions of the body systems are altered or interrupted (e.g., diseases, injuries, malformations, improper nutrition, drugs) performance may be affected.	CCG 2.1E

Conditioning Exercises (Concept IX)

The student knows that exercise under certain conditions should be avoided for safety and health reasons (e.g., extreme fatigue, painful muscle strain, irregular conditions).	CCG 2.1G

Nutrition (Concept XI)

The student knows the detrimental effects of harmful ingredients in food (e.g., cholesterol, caffeine, fats, drugs).	CCG 2.1E

* Physical Education Common Curriculum Goals, 1988, State of Oregon.

SCIENCE RECOMMENDATIONS

Why Infuse AOD Content in Science Courses

The Science teachers who worked on the AOD Curriculum Project during the summer of 1990 explored ways in which this important topic could be infused into existing Science classes. They believe that teaching Science skills using AOD content will benefit students both academically and personally as they make important life decisions.

Applicable Science Courses

The following are courses into which AOD curriculum can be infused:

- Introductory Physical Science
- Applied Life Science
- Applied Physical Science
- Biology

Appropriate course goals from Science courses were selected by Steve Carlson, Science Curriculum Specialist, and approved by the Department Chairpersons. They are listed on the following pages, with Common Curriculum Goals (CCG) noted.

Curriculum in Current Use

Presently, AOD content is included in many high school Science courses. The text for Applied Life Science, Prentice Hall Life Science, contains an excellent chapter on alcohol and drugs, including tobacco, and utilizes appropriate prevention teaching strategies. Initial exploration of other texts indicates that the topic is covered in some texts but more cooperative learning approaches should be added for greater prevention effectiveness. The Project teachers recommend that Science teachers who will be involved in this instruction read Bonnie Benard's article, "Knowing What to Do - and Not To Do - Reinvigorates Drug Education" which summarizes criteria for effective prevention education (see Appendix C).

Proposed New Materials

The Science teachers on the committee reviewed various materials available for instruction about alcohol and other drugs. Those most highly recommended were developed by classroom teachers for the P.A.C.T. project at the University of California at Irvine. These lessons are appropriate in content and teaching strategies. All Science Department Chairpersons received copies of these lessons in fall 1990. Master copies (paper or MacIntosh disk) are available from Sue Rowe, Curriculum Development and Support, 280-5840 ext. 474.

SCIENCE COURSE GOALS:

Introductory Physical Science – The students will:

describe interactions among science, technology, society, and the environment.	CCG* 6.1-6, 7.4

Applied Physical Science – The students will:

be provided opportunities to develop skills in identifying science-based societal problems and in making decisions about their resolution.	CCG 5.2, 5.3, 5.5, 5.6, 6.1-5
recognize the importance of continued scientific research to help solve problems which society faces.	CCG 5.2, 5.3, 5.5, 5.6, 6.1-5, 7.2

Applied Life Science – The students will:

understand the structure, function and classification of cells, tissues, organs and systems of plans and animals.	CCG 1.5, 1.7, 1.10, 1.14, 2.6, 2.9, 2.12, 2.14, 2.15, 3.1, 3.2
understand the principles of heredity and genetics.	CCG 1.6, 1.8, 1.10, 1.12, 1.15, 1.19, 2.1, 2.5, 2.9, 2.10-, 2.12, 2.13, 2.14, 3.1, 3.2, 3.3, 4.4, 5.4, 5.5, 5.6, 6.1, 6.2, 6.4
understand the interaction of living organisms and the environment.	CCG 1.5, 1.11, 2.5, 2.8, 2.9, 2.10, 2.14, 4.1, 6.1-5
be able to observe natural phenomena, record and organize these observations, draw valid conclusions to solve problems.	CCG 5.2, 5.5, 5.6, 6.1, 6.2, 6.3, 6.4, 6.5, 7.1, 7.2, 7.3
be able to use reference materials to secure the information necessary for a particular aspect of Applied Life Science.	CCG 4.1, 4.2, 4.3, 4.4
be provided opportunities to develop skills in identifying science-based societal problems and making decisions about their resolution.	CCG 5.3, 5.4, 5.6
recognize the importance of continued scientific research to help solve problems which society faces.	CCG 2.5, 2.9, 2.13, 4.4, 5.3, 5.6, 6.1-5, 7.2, 7.3

* Science Common Curriculum Goals, 1989, State of Oregon.

Biology – The students will:

understand the interaction of living organisms and the environment.	CCG* 1.5, 1.11, 2.5, 2.8, 2.9, 2.10, 2.14, 4.1, 6.1-5
understand the principles of heredity and genetics.	CCG 1.6, 1.8, 1.10, 1.12, 1.15, 1.19, 2.1, 2.5, 2.9, 2.10, 2.12, 2.13, 2.14, 3.1, 3.2, 3.3, 4.4, 5.4, 5.5, 5.6, 6.1, 6.2, 6.4
recognize the factors that influence population growth, stability and decline.	CCG 1.6
be able to use scientific methods to solve problems.	CCG 5.2, 5.5, 5.6, 6.1-5, 7.1, 7.2, 7.3
increase their interest and knowledge of biology by using a variety of reference material to secure the information.	CCG 4.1, 4.2, 4.3, 4.4
recognize the application of biological principles to daily experiences including health issues.	CCG 5.6

* Science Common Curriculum Goals, 1989, State of Oregon.

Recommended Science Infusion Lessons from P.A.C.T./Irvine Study for Middle School-High School Level Science Lessons

Material	Appropriate Grade Levels	Appropriate Classes			
		IPS	APS	ALS	B
Alcohol and Vision—#4	7-12		X	X	X
Alimentary, My Dear—#5	7-12			X	X
Batters Up—#10	7-8			X	X
Breathe Deep—#11	9-12		X	X	X
Daphnia's Heartrate—#22	9-12			X	X
Down the Hatch—#28	7-8			X	X
Drug Rap—#29	9-12	X	X	X	X
Egg Baby—#30	9-12		X	X	X
Fetal Alcohol Syndrome—#33	9-12	X	X	X	X
Fetal Development—#34	9-12			X	X
Food Handling in Paramecium—#35	7-12			X	X
Gateway to the Cell—#36	9-12			X	X
Genetic Mutations—#37	9-12				X
Let's Get Graphic—#51	7-8	X	X	X	X
Messengers of Nervous System—#53	9-12			X	X
Nicotine: Phototaxis—#54	9-12			X	X
Places in the Heart—#58	9-12			X	X
Reaction/Discrim. Time—#61	9-12			X	X
Science, Substances, You—#64	7-12	X	X	X	X
Steroids Jigsaw—#71	4-12				X
THC Treated Cells—#74	9-12				X

IPS = Introductory Physical Science
APS = Applied Physical Science;
ALS = Applied Life Science
B = Biology

NOTE: Copies of these lessons have been distributed to Science Chairpersons at each high school. Master copies, both hard copy and on MacIntosh disk, are available from Sue Rowe, Curriculum Development and Services, 280-5840 ext. 474.

Additional Science Resources for AOD Instruction

- *AOD High School Infusion*, Oregon Department of Education, 1990.
- *Education for Self-Responsibility II: Prevention of Drug Use*; Texas Education Agency, 1989.
- Oregon Law Related Education Program: *Courts and Trials; Drugs in the Schools; The Drug Question; Juvenile Responsibility and Law; Street Law; and Teens, Crime and the Community.*
- *Project Edahoe* (Enacting Drug Abuse Prevention Through Higher Opportunities in Education), Lewis-Clark State College, 1991.
- Western Center for Drug-Free Schools and Communities — drug prevention curricula, audiovisuals, and technical articles available.

Available from Sue Rowe
Curriculum Development and Services
280-5840 ext. 474.

SOCIAL STUDIES RECOMMENDATIONS

Why Infuse AOD Content in Social Studies Courses

The teachers on the AOD Project Committee believe Social Studies curriculum is well suited to the teaching of some AOD topics. Alcohol and other drugs have profound impact on a variety of national and international issues which are covered in Social Studies classes. These topics have academic as well as personal importance.

Applicable High School Social Studies Courses

The following are courses into which AOD curriculum can be infused:

- United States Government
- Global Studies
- Psychology*
- Sociology*
- Street Law*
- Economics*

*Note: See local school planned course statements.

Curriculum in Current Use

Some teachers are including this content in Social Studies classes at the present time. The AOD Curriculum Project teachers recommend that Social Studies teachers who will be involved in this instruction read Bonnie Benard's article, "Knowing What To Do - and Not To Do - Reinvigorates Drug Education," which summarizes criteria for effective prevention education (see Appendix C).

Proposed New Materials

After reviewing an array of Social Studies curriculum materials during the summer workshop, the Committee teachers recommended that the following course goals match the AOD expectations. Additional resources which are also recommended are from Oregon Law Related Education materials and lessons from the University of California Irvine/P.A.C.T. Project. These lessons were developed by classroom teachers for infusion of AOD content into Social Studies classes.

Social Studies Planned Course Statement Goals

The following goals, with Common Curriculum Goals (CCG) noted, were selected by Eleanor Hardt, Social Studies Curriculum Specialist, as those best suited for Alcohol and Other Drugs prevention education curriculum.

U. S. GOVERNMENT

Constitution

The student will understand that the Constitution provides a basic framework for the American legal system at all levels of government. The Constitution was based on principles and ideals and its effectiveness through the years can be critiqued. It is not a static document but changes as the result of judicial interpretation or amendment, often as the result of social forces. — CCG* 9.1, 9.2

Bill of Rights

The student will understand that the Bill of Rights represents a desire to guarantee to all people certain fundamental civil rights. Although these rights provide a framework, they are not exclusive and subject to reinterpretation as conditions change. — CCG 10.1

Federalism, Separation of Powers, Checks and Balances

The student will understand how power is divided and shared by the various levels of government and how each branch of government can limit the extent of power held by others. — CCG 9.3

Three Branches of Government

The student can identify the functions associated with each branch of government and the process by which each branch carries out its assigned function. — CCG 9.3

* Social Studies Common Curriculum Goals, 1990, State of Oregon.

GLOBAL STUDIES

Economic Development

The student will understand that economic development is affected by the legacy of colonialism and the industrial revolution, the presence of multinational corporations, the competition for development capital, the structure of the world economic order, and internal governmental decisions.

CCG* 1.5, 1.6

Competing Ideologies

The student will understand the role of competing ideologies in government policy, economic structure, and social conflict.

CCG 1.5, 1.6

* Social Studies Common Curriculum Goals, 1990, State of Oregon.

Additional Social Studies Resources for AOD Instruction

Material	Appropriate Grade Levels				Appropriate Classes			
	9	10	11	12	GS	USG	EC	SL
U.C. IRVINE/P.A.C.T. PROJECT Available from Sue Rowe, CD&S, 280-5840 x474.								
Anytown School Board-#6	X	X	X	X		X		
Leary v U.S.-#50				X		X		
The Right Decision-#62	X	X	X	X				
Teenage Drinking/Driving-#73		X	X	X		X		X
Worldwide War Against Smoking-#79					X		X	X
LAW RELATED EDUCATION MATERIALS Available at LRE Office, Terwilliger School, 245-8707								
Drugs in the Schools	X							
Law in Action Series								
Courts and Trials *	X							
Juvenile Responsibility and the Law	X							
State v Ballard [1]						X		
Street Law			X	X		X		
Teens, Crime and the Community	X	X	X	X				

GS = Global Studies; USG = U. S. Government; EC = Economics; SL = Street Law

* Appropriate teaching strategies are needed to make these materials useful.

[1] The Oregon Law Related Education Program has additional mock trail cases addressing AOD issues.

Additional Social Studies Resources for AOD Instruction

Law Related Education Materials

- *Bibliography: Oregon Law Related Education Program.* 1990.
- *Drugs in the Schools*, Center for Civic Education, 1990. $110 for a student set of 30 and teacher guide. Order from Center for Civic Education.
- *The Drug Question*, Constitutional Rights Foundation, 1990. $135 for a student set of 30 and teacher guide. Order from Constitutional Rights Foundation.
- *Law in Action Series*, Riekes-Ackerly, 1900-1990. West Publishing Company.
  - *Courts and Trails*, Third Edition, (Getting to Know the Court System; Mock Trials; Mediation; Glossary). $11.75 each, student and teacher editions.
  - *Juvenile Responsibility and the Law*, 1990. $13 student edition, $12.95 teacher edition.
- *State v Ballard*, Constitutional Rights Foundation, adapted by Oregon Law Related Education Project, 1985. Mock trial. Teenage drinking and driving using Oregon .08 alcohol percentage level for intoxication. $5. Can be copied.
- *Street Law*, Arbetman, McMahon, O'Brien, Fourth Edition, 1990. West Publishing Company. AOD focus lessons in criminal, family, housing, torts, and constitutional law chapters. $17.75 teacher guide, $15.96 (paper) or $20.56 (hardcover) student manual.
- *Teens, Crime, and the Community*, National Institute for Citizen Education in the Law, 1987. West Publishing Company. $17.75 teacher edition, $11.75 student edition.

Curriculum Infusion Lessons

- University of California Irvine/P.A.C.T. materials are individual lessons developed by teachers. May be copied. Available from Sue Rowe, Curriculum Development & Support, 280-5840 ext. 474.

- *Education for Self-Responsibility II: Prevention of Drug Use.* Texas Education Agency.

- *Project EDAHOE (Enacting Drug Abuse Prevention Through Higher Opportunities in Education).* Lewis-Clark State College. 1991.

Available from Sue Rowe, Curriculum Development and Services, 280-5840 ext. 474.

These materials were reviewed for use in Portland Public Schools Social Studies classes by:

- Pamela Hall, Lincoln High School
- Ron Hustead, Cleveland High School
- Robyn Larkin, Harriet Tubman Middle School

SPECIAL EDUCATION RECOMMENDATIONS

Introduction

Because of the high-risk nature of students in Special Education with respect to use of alcohol and other drugs, it is extremely important to include prevention education in Structured Learning Centers. The lessons listed on the following pages should not all be presented in one year, but spread out throughout the four to seven high school years. The lessons may not be developmentally appropriate for individual students and may need to be modified in order for the students to understand them. In addition to *Here's Looking At You, 2000* teachers may need to use supplemental instructional materials which address the Learner Outcomes.

Learner Outcomes from the *Here's Looking At You, 2000* curriculum have been selected for use by high school SLCs, rather than the high school course goals statements, because most students in SLCs will not be working toward a standard diploma. If students in SLCs can be appropriately mainstreamed into a health, science, social studies, or P.E. class when the AOD lessons are presented, the student does not need to receive the instruction in the SLC as well. Special Education teachers should review the completed high school planning matrix (see page 9) to determine which classes/grade levels will cover the material so they can plan for mainstreaming.

If students are working towards a standard diploma, or if they are placed in a Resource Center, it is recommended that they attend regular classes each year that include information, skills, and attitude development about alcohol and other drugs.

Some students have unique needs relating to issues of alcohol and other drugs. For these students, IEP goals and objectives should reflect these needs. Not all students will need IEP goals addressing alcohol and other drugs. All students, however, are required to have instruction in preventions strategies each year.

Teachers are urged to teach the skills lessons as early as possible in the school year, the bonding lessons throughout the year, and the information lessons in one unit at a time later in the year when trust has been built in the class to allow sensitive issues to be discussed.

HIGH SCHOOL SPECIAL EDUCATION - SLC-A and SLC-B
AOD Instructional Minimums

Learner Outcomes: The student will be observed:

INFORMATION		HLAY2000 7-9	HLAY2000 HS
I.01	identifying ways to maintain health and wellness	Lesson #27	All Health
I.02	defining a drug	Lessons #1,6	Lesson #1
I.03	identifying drugs and their effects	Lessons #1,6	Lessons#1,4,5,7,11,12,13
I.04	describing the dangers of unknown substances	Lessons #1,6	
I.05	identifying chemical dependency: individual/ family	Lesson #16	Lesson #1,3,19,20,31,26
I.06	describing the effects of alcohol	Lessons #7,8	Lessons #3,5
I.07	describing the effects of tobacco including secondhand smoke	Lessons #9,10	Lessons #7,8
I.08	describing the effects of marijuana	Lessons #11,12	Lessons #11,12
I.09	describing the effects of cocaine		Lesson #13
I.10	describing the effects of other drugs	Lesson #13	Lesson #14
I.15	describing how the AOD user/abuser hurts others	Lessons #15,16	Lessons #19,20
I.16	describing the effects of AOD and driving	Lesson #15	Lesson #17
I.18	defining reasons why people use/don't use AOD	Lesson #12	Lesson #18
I.24	describing the effects of AOD use on sexuality		Lesson #16
I.28	describing healthy alternatives to AOD use	Lesson #27	Lessons #11,12,18
I.29	describing the process of selection of friends, groups	Lessons #23,24,25	Lesson #18
I.30	describing the rules, laws, and consequences of AOD use	Lesson #20	Lesson #16,17
I.31	identifying school, district, and community AOD resources	Alcohol and Drug Specialist can assist with this information.	Alcohol and Drug Specialist can assist with this information.

SKILLS

Communication/Social Skills

S.02	demonstrating resistance/refusal skills	Lessons #23,24,25,26	Lessons #10,12,15,16
S.03	demonstrating friendship skills	Lessons #3,4,5	Lessons #2,18,23,24

Decision Making/Problem Solving Skills

S.05	utilizing decision-making skills	Lesson "#26	Lesson #29
S.06	identifying sources of pressure influence	Lesson #26,19,10	Lessons #2,27,8
S.07	defining goals		Lesson #10
S.08	making healthy decisions	Lessons #14,19	Lessons #17,21,29

AFFECTIVE/ATTITUDE LEARNER OUTCOMES

Teachers are urged to include lessons on the topics of self-concept, self-esteem, stress management, and friendship development from district adopted health materials, supplemental materials from the AV Library, their own resources, as well as the *Here's Looking at You, 2000* materials.

HIGH SCHOOL SPECIAL EDUCATION - LIFE SKILLS
AOD Instructional Minimums

Learner Outcomes: The student will be observed:

INFORMATION		HLAY2000 LESSON/OTHER
I.01	identifying ways to maintain a healthy body	All Health Lessons
I.02	defining a drug	Gr3: #2 *Learning About Drugs* Gr5: #2 *Internal Organs*
I.03	identifying drugs and their effects	Gr3: #2 *Learning About Drugs* Gr4: #4 *Reasons and Risks* Gr5: #2 *Internal Organs* Also *Growing Free. an Alcohol and Drug Life Skills Program* (PPS, 1986) [1]
I.04	describing the dangers of unknown substances	GrK-1: #3 *Drug Look Alikes*
I.05	identifying chemical dependency: individual/ family	Gr3: #5 *John Has a Disease* Gr5: #6 *Fishing for Answers*
I.06	describing the effects of alcohol	Gr3: #2 *Learning About Drugs* Gr5: #2 *Internal Organs* Gr4: #6 *Bottle of Questions*
I.07	describing the effects of tobacco including secondhand smoke	Gr3: #3 *A Drug that is not a Medicine* Gr4: #4 *Reasons and Risks* (Fact Sheet) Gr4: #8 *Tobacco, Chew* Gr5: #4 *The Problems Add Up*
I.08	describing the effects of marijuana	Gr4: #4 *Reasons and Risks* Gr5: #4 *The Problems Add Up*
I.09	describing the effects of cocaine	Gr4: #4 *Reasons and Risks*
I.10	describing the effects of other drugs	Gr4: #4 *Reasons and Risks* (Fact Sheet)
I.12	describing the factors which influence AOD effects	Gr4: #4 *Reasons and Risks* (Fact Sheet)
I.13	describing AOD affected children	*Preventing Drug Affected Babies*[2]
I.14	describing the relationship AOD and disease	See Fact Sheets on Alcohol, Nicotine, Marijuana
I.19	describing the risk factors AOD use/abuse and ways to reduce them	Gr4: #5 *Lowering Your Risks* Gr5: #6 *Fishing for Answers*
I.27	describing family, cultural, and societal norms, including AOD use	See Teacher Notes
I.28	describing healthy alternatives to AOD use	Gr4: #2 *Lots to Do That's Fun* Gr5: #7 *Less Stress* Gr5: #8 *Visitor from Planet Drugless*
I.29	describing the process of selection of friends, groups	*Circles I* [3]
I.30	describing the rules, laws, and consequences of AOD use	Review District Student Handbook
I.31	identifying school, district, and community AOD resources	Contact A&D Specialist or school Social Worker

SKILLS

Communication/Social Skills

S.01	asking for what he/she wants/needs	Ask school counselor, speech pathologist
S.02	demonstrating refusal skills	*Circles I* Gr5: #16-20 *Say No and Keep Your Friends*
S.03	demonstrating friendship skills	Gr5: #16-20 *Say No and Keep Your Friends*
S.04	demonstrating listening skills and abiding by rules in open-ended discussion	*Circles I*, speech pathologist

Decision Making/Problem Solving Skills

S.05	utilizing decision-making skills	Gr4: #12 *What Would You Do with $1,000?* Gr5: #14 *Deciding* *Circles I*
S.06	identifying sources of pressure influence	*Circles I* Gr5: #16-20 *Say No and Keep Your Friends* Gr5: #1 *Coat of Arms*
S.07	defining goals	*Go For It*
S.08	making healthy decisions	All lessons

AFFECTIVE/ATTITUDE LEARNER OUTCOMES

Teachers are urged to include lessons on the topics of self-concept, self-esteem, stress management, and friendship development from supplemental materials from the AV Library, their own resources, as well as the *Here's Looking at You, 2000* materials.

Teacher Notes:

(1) *Growing Free* is available from the Child Development Specialists Program, Student Services Department, Child Services Center.

(2) *Preventing Drug Affected Babies* available in every school.

(3) *Circles I* may be ordered from the AV catalog.

APPENDICES

Appendix A
OAR 581-22-413

65th OREGON LEGISLATIVE ASSEMBLY-1989 Regular Session

B-Engrossed
Senate Bill 584

Ordered by the House May 30
Including Senate Amendments dated May 10 and House Amendments dated May 30

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor Goldschmidt)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires school districts and state institutions of higher education to establish and implement alcohol and drug abuse policy and plan. Requires Office of Alcohol and Drug Abuse Programs to develop public information program and contact advocacy groups to facilitate outreach and disseminate prevention information. Requires State Boards of Education and Higher Education, in consultation with office, to adopt by rule minimum descriptions of content. Requires departments and office to report to regular sessions of Legislative Assembly and to Governor on progress and effectiveness of policy and plan.

A BILL FOR AN ACT

Relating to alcohol and drug policies for educational institutions.

Be It Enacted by the People of the State of Oregon:

SECTION 1. In accordance with rules adopted by the State Board of Education in consultation with the office of Alcohol and Drug Abuse Programs, each district school board shall adopt a comprehensive alcohol and drug abuse policy and implementation plan, including but not limited to:

(1) Alcohol and drug abuse prevention curriculum and public information programs addressing students, parents, teachers, administrators and school board members;

(2) The nature and extent of the district's expectation of intervention with students who appear to have drug or alcohol abuse problems;

(3) The extent of the district's alcohol and other drug prevention and intervention programs; and

(4) The district's strategy to gain access to federal funds available for drug abuse prevention programs.

SECTION 2. To assist school districts to formulate the programs described in subsection (1) of section 1 of this Act, the office of Alcohol and Drug Abuse Programs shall:

(1) Devise a public information program directed toward students, parents, teachers, administrators and school board members at the school district level; and

(2) Contact advocacy associations of the target groups described in subsection (1) of this section to facilitate outreach programs and disseminate alcohol and drug abuse prevention information.

SECTION 3. In consultation with the office of Alcohol and Drug Abuse Programs, each state institution of higher education shall adopt a comprehensive alcohol and drug abuse policy and implementation plan.

NOTE: Matter in bold face in an amended section is new matter *[italic and bracketed]* is existing law to be omitted.

SECTION 4. In order to carry out the duties described in sections 1 and 2 of this Act, the State Eng. Board of Education, in consultation with the office of Alcohol and Drug Abuse Programs, shall adopt by rule, as a minimum, descriptions of the content of what shall be included in the policy and plan described in sections 1 and 2 of this Act.

SECTION 5. In order to carry out the duties described in section 3 of this Act, the State Board of Higher Education, in consultation with the office of Alcohol and Drug Abuse Programs, shall adopt by rule, as a minimum, descriptions of the content of what shall be included in the policy and plan described in section 3 of this Act.

SECTION 6. The Department of Education, the State System of Higher Education and the office of Alcohol and Drug Abuse Programs shall report to regular sessions of the Legislative Assembly and to the Governor on the progress and effectiveness of the policies and plans described in sections 1 to 3 of this Act by submitting a copy of the report to the offices of the President of the Senate, the Speaker of the House of Representatives and to the Governor.

NOTE: Matter in bold face in an amended section is new matter *[italic and bracketed]* is existing law to be omitted.

Oregon Administrative Rule 581-22-413
Prevention Education Programs in Drugs and Alcohol

Statutory Authority: 326.010
SBE
OAR

581-22-413
Prevention Education Programs in Drugs and Alcohol

The statutory authority for this rule is ORS 326.011, 336.222, 336.227, 336.235, and 336.245.

(1) Each school district shall develop a plan for a drug and alcohol prevention program which shall include:
  (a) Drug and alcohol prevention instruction as an integral part of the district's comprehensive health education program. In addition, at least annually, all senior high school students shall receive age-appropriate instruction about drug and alcohol prevention.
  (A) The age-appropriate curriculum for this instruction shall:
    (i) emphasize prevention,
    (ii) be reviewed and updated annually to reflect current research, and
    (iii) be consistent with State Board adopted Health Education Common Curriculum Goals.
  (B) Basic information shall include:
    (i) the effects of alcohol, tobacco, and other drug use,
    (ii) all laws relating to the use, especially by minors, of alcohol and other illegal drugs, and
    (iii) the availability of school and community resources.
  (C) The instructional program shall include activities which will assist students in developing and reinforcing skills to:
    (i) understand and manage peer pressure,
    (ii) understand the consequences of consuming alcohol and other drugs,
    (iii) make informed and responsible decisions, and
    (iv) motivate students to adopt positive attitudes towards health and wellness.
  (b) A public information program for students, parents, and district staff; and
  (c) Policies, rules, and procedures which:
    (A) include a philosophy statement relating to drug-free schools,
    (B) define the nature and extent of the district's program, including a plan to access and use federal funds,
    (C) state that alcohol, tobacco, and other drug use by students is illegal and harmful,

(D) in accordance with OAR 581-21-050 and OAR 581-21-055, indicate the consequences for using and/or selling alcohol and other drugs, including the specific role of the school as it relates to law enforcement agencies,

(E) describe the district's intervention and referral procedures, including those for drug-related medical emergencies,

(F) indicate clearly that the school district's jurisdiction includes all school sponsored events including student activities, and

(G) are reviewed and updated annually beginning with the 1990-91 school year.

(2) The district's drug and alcohol prevention and intervention program shall be approved by the school district board after consultation from parents, teachers, school administrators, local community agencies, and persons from the health or alcohol and drug service community who are knowledgeable of the latest research information.

(3) Staff development in the district shall:

(a) Inform all staff of the district plan and their responsibilities within that plan; and

(b) Provide drug and alcohol prevention education to all staff.

dc OAR20
3/12/90

OREGON ADMINISTRATIVE RULE 531-22-413
Prevention Education Programs in Drug and Alcohol
Questions and Answers

1. How did this administrative rule originate?

OAR 531-22-413 is based on ORS 336.222 which is the result of Senate Bill 584. The OAR was drafted by the Oregon Department of Education in consultation with the Oregon Office of Alcohol and Substance Abuse.

2. What must the district do to comply with OAR 581-22-413?

The district must:

a. develop a written plan for a drug and alcohol prevention program to include: 1) drug and alcohol prevention instruction; 2) a public information program; 3) policy, rules, and procedures. OAR Sec. (1)
b. have the plan for a drug and alcohol prevention program approved by the school board after consulting with the community. OAR Sec. (2)
c. provide a staff development program for all staff in the areas of drug and alcohol information, prevention, and their responsibility. OAR Sec. (3)

3. When must implementation of the drug and alcohol prevention program begin?

A drug and alcohol prevention plan and instructional program must be ready for implementation in September 1990.

4. What is meant by a drug and alcohol prevention program?

A drug and alcohol prevention program may be defined as a variety of activities, information, and materials aimed toward all students. The goal of prevention programs is to prevent the onset of substance use through educational awareness and skill development. The process of developing a model prevention program includes five major components: a) district policy; b) information to parents, students, staff, and community; c) social skill development for students; d) promotion of alternatives to the use of drugs, alcohol, and tobacco; e) staff development and inservice for all staff.

5. What does it mean to make drug and alcohol prevention instruction "an integral part of the district's comprehensive health education program"?

A comprehensive health education program includes:

a. Curriculum and instruction. The minimum expected would be the components listed in this OAR infused into a health education curriculum. In keeping with sound educational practice, the Department of Education also recommends integrating drug/alcohol instruction in other content ares.

b. Student services. This could include health services; support services such as student support groups, workshops, and conferences; and extra curricular activities such as clubs, athletics, dances, and assemblies.

c. School climate. This includes not only the social and educational component of the school, but also the school's physical environment such as student supervision, lockers, clothing, bulletin boards, posters, drug free workplace, etc.

6. How does the OAR address senior high school?

The OAR requires that drug and alcohol prevention education become an integral part of the high school health requirement for the equivalent of one full year of instruction or one credit. In addition, a district is required to have drug and alcohol prevention instruction annually in those years where health education is not required.

The manner and form of the instruction is left to the discretion of the district. In developing the plan for annual instruction, it is important for the district to consider what is reasonable, appropriate and effective. It may be reasonable to have an assembly that addresses these areas as one component of a total prevention program, but in and of itself this may not be effective as reinforcement nor would it provide more current knowledge and research. It might be more appropriate and effective to include activities exploring social and economic issues in Social Studies, Personal Finance, and English; chemical dependency in Science; family issues in Home Economics; fitness and performance issues in Physical Education. In the final analysis, however, this is a local district's decision.

7. What is age-appropriate curriculum?

It is curriculum determined to be developmentally appropriate according to proven educational practice and consistent with community values and attitudes. It is the responsibility of each district to decide this issue after consultation with parents, teachers, school administrators, local community agencies and persons from the health or alcohol and drug service community.

8. Basic information must include "all laws related to use." How is this interpreted?

This includes federal laws, state statutes, county regulations and city (municipal) ordinances as they relate to use, possession and distribution by minors. For county regulations contact your district attorney, and for city (municipal) ordinances contact your city attorney. At the state level, the following statutes relate to alcohol and drugs:

a. ORS 809.260 — Zero Tolerance for Alcohol for a Minor and Loss of Driving Privilege.

b. ORS 475.999 — Drug-Free School Zone.

c. ORS 475.992 — Marijuana Possession.

d. ORS 475.525 — Drug Paraphernalia Act.

e. ORS 475.005–475.997 — Oregon's Uniform Controlled Substance Act.

f. ORS 163.575 — Tobacco Sales to Minors.

A full set of ORS in which these laws are outlined can be found in any county or city library.

9. What are examples of school and community resources?

These resources can include drug-free school activities, available school personnel (counselor, nurse, teachers), as well as student clubs and groups, community activities, YMCA, YWCA, and church groups. Other community resources include county drug and alcohol prevention coordinators, mental health professionals, treatment centers, hotlines, clinics, Oregon Prevention Resource Center, Alateen, etc.

10. The rule refers to "managing peer pressure as a skill." What are some of these skills? What are available resources for teachers?

Managing peer pressure includes age and developmentally appropriate skills of how to say no. This should include techniques in refusal skills, i.e., learning to ask for something, saying no to self, say no and keep friends, how to stay out of trouble. County prevention coordinators, school counselors, Oregon Prevention Resource Center, as well as the Department of Education are all resources for such materials.

11. How can the instructional program teach about the consequences of consuming alcohol and other drugs?

An understanding of the consequences can be taught through cooperative learning-based instruction which should focus on decision-making and problem-solving activities. Consequences should be focused on the immediate. Research suggests that for adolescents, long-term consequences have little effect on behavior (e.g., 30 years from now you may die of lung cancer if you smoke or chew tobacco). Immediate consequences are social (friends, school, family), emotional, physical, as well as legal aspects (i.e., your clothes and breath smell when you smoke or chew; if you are between 13–17 years of age and possess, use or abuse alcohol or any other controlled substance, your driver's license and/or permit will be denied).

12. How can a district comply with providing public information programs for students, parents, and district staff?

The main point is to let the public know what you are doing about the drug and alcohol issue. Activities could include newsletters, articles, parent-community nights, "Preparing for the Drug (Free) Years," student-community anti-drug campaigns, posting "drug free school zone" signs, keeping informed of latest research and driving laws.

13. What is meant by "a philosophy statement relating to drug free schools"?

Drug free schools are those which send an absolute and clear message that possession, selling, or use of tobacco, alcohol, and other illegal drugs will not be tolerated in the schools, on school grounds, or during school sponsored activities, including athletic events, dances, field trips, etc. The application for drug free schools grants requires that this message be included in the district's written policy as well s reflected in written procedures.

14. Must districts apply for federal monies?

Yes, the rule requires this. Every district has access to drug free school monies from the 1986 Drug Free School Act and must now document how they intend to apply for the money each year. Besides direct applying, this could be accomplished through coordinated efforts with community agencies, education service districts, or other districts.

15. How are OAR 581-21-050 and 055 related to this rule?

The administrative rules 581-21-050 and 055 are referenced because they address school district boards' responsibility to have written rules concerning disciplinary actions associated with using alcohol, drugs, and tobacco.

16. What is meant by "role of the school as it relates to law enforcement agencies"?

Policy and procedures must reflect under what circumstances the school will notify law enforcement agencies when a student is in possession, distributing, or under the influence of drugs or alcohol.

17. What is the district's responsibility for an intervention and referral procedure?

Intervention can be defined as the identification and referral of students whose behavior is interfering with their potential success socially, emotionally, physiologically, and/or legally as a result of illegal use of drugs and alcohol. The rule requires that policies and procedures be adopted to inform students, parents, and staff about intervention and referral procedures.

18. What are the schools' responsibilities concerning drug-related medical emergencies?

Drug-related medical emergencies may include overdoses or allergic reactions which could result in cardiac or respiratory arrest, or suicide attempts. This administrative rule requires districts to have written procedures for responding to these emergencies.

19. What must be included in staff development?

Staff development includes a planned program that addresses the needs for the entire staff yearly, including the teaching faculty, bus drivers, custodians, food service, secretaries, and others. Staff development should include:

a. basic drug and alcohol information.

b. an explanation of district and school drug and alcohol policies, procedures, and program.

c. an inservice:
   1) that actively involves participants in planning and implementation; and
   2) which provides a sufficient length of time to achieve a and b.
   3) that speaks to the various levels of background among staff members.

20. Is there a required state curriculum?

No. Local districts may adopt existing programs or develop their own. The program must be consistent with the state's Health Common Curriculum Goals and be part of the total comprehensive health program.

However, a K-8 infused drug/alcohol curriculum guide is being developed through a federally funded grant at Eastern Oregon State College in cooperation with the Oregon Department of Education. Piloting of this guide will be completed in the fall of 1990 with final copy available in the fall of 1991.

For information regarding implementation of Drug and Alcohol Prevention Education Programs, you may contact the following agencies:

Oregon Department of Education	378-8870
Oregon Prevention Resource Center	378-8000
Office of Alcohol and Drug Abuse Programs	378-2163

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Appendix B

"Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention"

by

J. D. Hawkins, R. F. Catalano, and J. Y. Miller

Psychological Bulletin (in press).

RISK FACTORS FOR ADOLESCENT SUBSTANCE ABUSE

FAMILY FACTORS:

1. Family History of Alcoholism
2. Family Management Problems
3. Parental Use and Positive Attitude Toward Use

SCHOOL FACTORS:

4. Early Conduct Problems
5. Academic Failure
6. Little Commitment to School

ATTITUDES, BEHAVIORS:

7. Antisocial Behavior in Early Adolescence
8. Favorable Attitude toward Drug Use
9. Early First Use
10. Alienation, Rebelliousness, Lack of Social Bonding

PEER FACTORS:

11. Friends Who Use Drugs

ENVIRONMENTAL FACTORS:

12. Economic and Social Deprivation
13. Low Neighborhood Attachment and Community Disorganization
14. Transitions and Mobility
15. Community Laws and Norms Favorable Toward Drug Use
16. Availability of Drugs

Hawkins, J.D., Lishner, D.M., Catalano, R.F., Howard, M.O. Childhood predictors of adolescent substance abuse: Toward an empirically grounded theory. Journal of Contemporary Society. (in press).

WHAT ARE THE RISK FACTORS FOR TEENAGE DRUG ABUSE?

Knowing these risk factors can help us to prevent drug abuse before it occurs. By addressing factors associated with higher risk and increasing factors associated with low risk, we can decrease the chances that our children will develop problems with drugs.

These factors are summarized from research by the Social Development Research Group at the University of Washington School of Social Work and are discussed in the article "Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention," in the Psychological Bulletin (in press) by J.D. Hawkins, R.F. Catalano, and J.Y. Miller.

1. **FAMILY HISTORY OF ALCOHOLISM**
   When children are born to or raised by an alcoholic parent, their risk of abusing drugs is increased. For boys, this increased risk is a result of both genetic and environmental factors. Sons of alcoholic fathers are up to four times more likely to abuse alcohol than boys without an alcoholic father, even if not raised by that father. For both boys and girls, alcoholic parents provide a powerful role model for drinking that influences children's behavior.

2. **FAMILY MANAGEMENT PROBLEMS**
   Poor family management practices increase the risk that children will abuse drugs. Research has shown that in families where expectations are unclear or inconsistent, where there is poor monitoring of children's whereabouts and behavior, where children are seldom praised for doing well, and where punishment is inconsistent or excessive, there is greater risk that children will develop drug abuse problems.

   Children who grow up in homes where rules are not clearly stated and enforced have difficulty knowing what is expected of them. If they are not consistently recognized for their positive efforts and for doing well, then children fail to learn that their good behavior makes a difference. Similarly, if they are not consistently and appropriately disciplined for breaking family rules, they don't experience the security of knowing right from wrong and are less likely to develop their own good judgment.

   Bonding to families and attachment to parents have been shown to be negatively related to drug use. In order to make good decisions about their behavior, children need clear guidelines for acceptable and unacceptable behavior from their family. They need to be taught basic skills, and they need to be provided with consistent support and recognition for acceptable behaviors as well as consistent but appropriate punishment for unacceptable behaviors. They also need to know that their parents care enough to monitor their behavior so that rewards and consequences are applied fairly.

3. PARENTAL DRUG USE AND POSITIVE ATTITUDES TOWARDS USE

If family members use illegal drugs around children, if there is heavy recreational drinking in the home, or is adults in the family involve their children in their drinking or other drug use, such as asking a child to get a beer or light a cigarette, the children have an increased risk of developing problems with alcohol or other drugs.

Parents' attitudes about teenagers' use of alcohol seem to influence their children's use of other drugs as well. A survey of ninth grade children in King County, Washington showed that those children whose parents approved of teenage drinking under parental supervision were more likely to have used and to be using marijuana in ninth grade than were children of parents who disapproved of supervised teenage drinking at home. Parental approval of children's moderate drinking, even under parental supervision, appeared to increase the risk of children's use of marijuana.

4. EARLY CONDUCT PROBLEMS

A relationship has been found between male aggressiveness in kindergarten through second grade and delinquency and teenage drug abuse. The risk is especially significant when this aggressiveness is coupled with shyness and withdrawal. About 40% of boys with serious aggressive behavior problems in early elementary grades will develop delinquency and drug problems as teenagers.

5. ACADEMIC FAILURE (beginning in mid to late elementary school)

Children who do poorly in school beginning in approximately the fourth grade have an increased risk of abusing drugs. Children who fail in school for whatever reason—boredom, lack of ability, a mismatch with a poorly skilled teacher—are more likely to experiment early with drugs and to become regular users of drugs in adolescence.

6. LITTLE COMMITMENT TO SCHOOL

Children who are not bonded to school for whatever reason are more likely to engage in drug use. The annual surveys of high school seniors by Johnston, Bachman and O'Malley show that the use of strong drugs like cocaine, stimulants, and hallucinogens remains significantly lower among high school students who expect to go to college. Drug users are more likely to be absent from school, to cut classes, and to perform poorly than non-users. Factors such as how much students like school, time spent on homework, and perception of the relevance of coursework are also related to levels of drug use.

7. ANTISOCIAL BEHAVIOR IN EARLY ADOLESCENCE

This risk factor includes a wide variety of antisocial behaviors including school misbehavior and a low sense of social responsibility. Fighting, skipping school, and general aggressiveness have been shown to be related to drug abuse.

8. **FRIENDS WHO USE DRUGS**
   Association with drug–using friends during adolescence is among the strongest predictors of adolescent drug use. The evidence is clear that initiation into drug use happens most frequently through the influence of close friends rather than from drug offers from strangers. This means that even children who grow up without other risk factors but who associate with children who use drugs are at an increased risk for drug use and developing problems with drugs. This risk factor underscores the power of peer influence on teenagers.

9. **ALIENATION, REBELLIOUSNESS, LACK OF SOCIAL BONDING**
   In middle or junior high school, those students who rebel against authority, particularly their parents and school officials, and who do not attend church tend to be at higher risk for drug abuse than those who are bonded to the primary social groups of family, school, church, and community.

10. **FAVORABLE ATTITUDES TOWARD DRUG USE**
    Children in late elementary school often have very strong negative feelings against drugs. Yet by the time these children enter junior high school, they may begin associating with peers who use drugs, and their attitudes can quickly change. This shift in attitude often comes just before children begin to experiment with alcohol or other drugs. Research has shown that initiation into the use of substances is preceded by values favorable to substance use.

11. **EARLY DRUG USE**
    Early onset of drug use predicts subsequent misuse of drugs. The earlier the onset of any drug use, the greater is the probability of the individual's involvement in other drug use, the frequency of use, and their involvement in deviant activities such as crime and selling drugs. Children who begin to use drugs before age 15 are twice as likely to develop problems with drugs than are children who wait until they are older. Waiting until age 19 to try alcohol or other drugs dramatically decreases the risk of drug problems.

12. **COMMUNITY LAWS AND NORMS FAVORABLE TOWARD DRUG USE**
    Communities with laws favorable to drug use, such as low drinking ages and low taxes on alcohol, have higher rates of alcohol–related traffic fatalities and deaths due to cirrhosis of the liver. The availability of alcohol and illegal drugs is associated with use. Research has shown that greater drug availability in schools increases the use of drugs beyond other risk characteristics of individuals. Community attitudes favorable toward teenage drug use increase the risk of drug abuse.

13. **AVAILABILITY OF DRUGS**
    The availability of drugs in dependent, in part, on the laws and norms of society. Nevertheless, as suggested by Watts and Rabow (1983), availability is a separable factor. Whether particular substances are legal or proscribed by law, their availability may very with other factors. When alcohol is more available, the prevalence of drinking, the amount of alcohol consumed, and the heavy use of alcohol all increase (Gorsuch & Butler, 1976). Similarly, the availability of illegal drugs in associated with use.

14. EXTREME ECONOMIC DEPRIVATION

Poverty in and of itself is not a risk factor. However, children from families who experience social isolation, extreme poverty, and poor living conditions are at elevated risk of chronic drug abuse.

15. LOW NEIGHBORHOOD ATTACHMENT AND COMMUNITY DISORGANIZATION

Neighborhoods with a high population density, high rates of crime and lack of natural surveillance of public places have high rates of juvenile delinquency as well. Research has also found that attachment to neighborhood is a factor in inhibiting crime.

Studies have shown that neighborhood disorganization is a factor in the breakdown of the ability of traditional social units, such as families, to provide pro-social values to youth. When this occurs, there is an increase in delinquency in these communities.

It is likely that disorganized communities have less ability to limit drug use among adolescents as well.

16. TRANSITIONS AND MOBILITY

Transitions, such as those between elementary and middle or junior high school, and residential moves, are associated with increased rates of antisocial adolescent behavior—including rates of drug initiation and frequency of use.

Appendix C

"Knowing What to Do—and Not to Do—Reinvigorates Drug Education"

by

Bonnie Benard, Barbara Fafoglia, and Jan Perone

CHAPTER 1

Knowing What To Do–And Not To Do–Reinvigorates Drug Education *

By **Bonnie Benard, Barbara Fafoglia and Jan Perone.**

The hopeful future of drug and alcohol prevention contrasts sharply with former unrequited drug education programs and the dispiriting accounts of youthful drug use portrayed in the popular press.

Recent analyses have pinpointed why past school-based drug and alcohol education has proven ineffectual and recommended a reconceptualized approach. Research is also beginning to document positive outcomes for a relatively recent prevention model. On the basis of these two trends alone, educators have just cause to feel excited about what schools can do to prevent substance abuse.

It is fair to say that educators have had more experience than success with substance prevention programs. Alcohol education meant to curtail adolescent drinking has been mandated by law in most states over the past 80 years.[1] When the drug culture youth of the 1960s tuned in, turned on, and dropped out, schools stepped up their involvement in drug education.

The strategy in the late 1960s and early '70s was usually an information-only approach. Several researchers found that these programs–which often used scare tactics in hour-long, hit-and-run lectures–actually *increased* alcohol and drug use.

As a result, the pendulum swung in the mid-1970s from the drug to the person who might take the drug. Programs focused on affective strategies like self-esteem enhancement, values clarification, and such life skills as coping, communication, problem solving and decision making. Alcohol and drug information was often entirely omitted. Research studies soon began to indicate that these affective approaches also failed to lower substance abuse rates.

Consequently, in the late '70s, more sophisticated curriculums included both cognitive and affective components. [Editor's Note: See Appendix B–"Cognitive

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and Social Development: Program Implications."] The promise of this third generation of prevention programs may have been obscured by a faltering start. Longitudinal data have not yet been compiled, but preliminary evaluations have not shown significantly lower levels of substance use.[2] Because of these discouraging outcomes, many people now question whether alcohol and drug education even has the potential to change behavior.

Recent critical analyses of programs, however, have revealed flaws *that can be corrected.* Furthermore, a new social psychological model, guiding what might be thought of as a second cohort in the third generation of prevention programs, at last appears to be producing good results.

What can we realistically expect of school-based substance abuse prevention programs? To answer this, we look first at the problems with past programs, next at the reasons for schools to keep pursuing effective prevention strategies, then at two sets of specific and feasible activities schools can carry out, and finally at reasonable expectations for these efforts.

WHAT'S WRONG WITH SCHOOL-BASED PREVENTION

In recent drug education literature (by Thompson and others, Kellam and others, Barnes, Weisheit, and Goodstadt), a general consensus shows that five overlapping defects have diminished the effectiveness of school-based substance abuse prevention:

Designers have set unrealistic goals for programs and have not challenged unrealistic expectations from society.

Programs have established indicators of success that are so ambitious that the probability of achieving them is minute. Thompson and her colleagues elaborate:

> Prevention is unrealistic as a purpose of alcohol education if it is meant to imply eradication. Prevention of all alcohol problems and all risk for them could be accomplished only through complete elimination of alcohol from society.[3]

Not only do drug educators ask too much of themselves, society has put a disproportionate faith in the impact of schools working alone. Thompson declared flatly:

> Alcohol education is attributed a larger role than it can logically carry. Choices people make are influenced by a myriad of factors over which the school system has limited or no control–family, religion, emotional health, societal customs, media, laws, etc.[4]

Goodstadt and Barnes agreed, faulting the objectives of drug education for ignoring the strong influence of other "socialization agents."[5]

School-based programs have operated without a sound theory base.

The unrealistic expectations for schools stem, in part, from failure to base programs on a theoretical perspective that is firmly grounded in the behavioral and social sciences. For example, socialization theory reasons that substance use among youth is "learned, social behavior that is part of the adolescent socialization process anticipatory of the transition from childhood to adult status."[6]

Prevention programs based on this theoretical perspective would recognize that drinking among adults in America is normative social behavior.[7] Thus, schools'

substance abuse prevention efforts should create more modest and realistic goals for schools and work more with other significant social systems–the family, peer group, and mass media.

Past programs have not been guided by prevention principles.

The discipline of prevention has evolved from a narrow conception that tries to stop or reduce the likelihood of an event (like substance abuse). The newer, broader base interprets prevention as a complex set of activities that develop people's personal and social competencies and that modify social systems so as to better meet people's needs.

This expanded view assumes (with support from a growing body of research) that enriched personal and social development helps to immunize people from developing inter- and intrapersonal problems, which then lead to negative social consequences, including substance abuse, child abuse, delinquency, and teen pregnancy.

Basic prevention strategies do not stop after providing accurate information. They go on to build life skills (such as problem solving, decision making, and communication), promote healthy alternatives, influence social policies and cultural norms, and involve and train people who can have an impact on problems.

Previous prevention efforts have lacked intensity because they have been too limited in time and scope.

Ralph Weisheit points out how unrealistic it is to expect a few hours of classroom instruction to supersede "a lifetime of learning about alcohol from peers, parents, and the larger community."[8]

While a recent evaluation of the popular CASPAR curriculum (third generation of programs, first cohort) found no evidence of an effect on drinking behavior, Lena DiCicco and colleagues noted that "where alcohol education was implemented most *intensively* and *continuously* at the junior high school level, misuse did not rise as sharply as it did among the comparison children."[9] She concludes that "changing youthful drinking is tantamount to changing a culture . . . We hope that continuing intensive efforts over a long period will produce more rapid social change."[10] Goodstadt's evaluation of drug education programs, similarly, recommended that "the intensity of drug education be significantly increased."[11]

Social learning theory also points to the need to broaden the scope of prevention efforts. The principles of social learning stipulate that the more comprehensive the prevention–that is, the more social systems involved–the greater the likelihood of positive behavior acquisition and reinforcement. An ideal prevention program would not only employ all five prevention strategies but do so in a systems context that ties school programs in with other social systems.

School-based prevention has stopped short of adequate implementation.

Usually, evaluations concluded, this fault line runs primarily over insufficient teacher training.

WHAT'S POSSIBLE WITH SCHOOL-BASED PREVENTION

Schools are assuming an increasingly central place in the lives of youth. As Kenneth Polk has observed, not only do youths spend most of their time there, but "school status and success [determine] life chances of students in many social and economic dimensions, in both the present and future."[12] In his opinion, "fundamental economic and social changes in recent decades have changed the meaning of youth, especially in terms of the emergent centrality of the school, making it the dominant social setting in the life of the adolescent."[13]

Whether school life should hold such sway is immaterial, because whether it should or shouldn't, the fact remains that it does. The pivotal role schools play, however, confers on this particular social institution important advantages for prevention programming. Weisheit itemizes them:

- access to youth on a large scale,
- economic feasibility,
- opportunity for longitudinal interventions,
- experienced teachers already in place, exploratory research (a need repeatedly expressed by prevention researchers), and
- a sense of public legitimacy.[14]

Schools are thus uniquely poised to affect the irresponsible use of drugs and alcohol. We now know much more clearly what schools can do.

Schools can cooperate in a comprehensive prevention effort that involves families, community groups, and the media.

The most engaging efforts of schools cannot overcome a cultural context that not only reflects ambivalence about alcohol and drug use, but that actually promotes use, especially by young adults. Schools alone cannot reverse mass media and governmental policies, for example, that facilitate alcohol advertising on television.

School programs cannot deny the direct subsidies with which government actively supports the production of tobacco, our most dangerous drug in terms of lost lives, diminished health, and costs to society.

Community prevention efforts must focus on formal changes in public policies at local, state and national levels. Policies that encourage the use of alcohol and drugs must be rescinded, and policies that provide opportunities for meaningful education and employment need to be created.

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Prevention must also aim to effect informal social policy changes. Community and cultural norms can be altered by public awareness campaigns that include a strong media component and extend beyond schools to families and community institutions.

The effectiveness of such an approach is evident in the positive outcomes of various community heart disease prevention programs (and their derivative anti-smoking campaigns), which have shown significant reductions in the onset of negative health behaviors, the incidence of the behaviors, and the frequency of related morbidity and mortality. These programs were both comprehensive and intense; they all included a family involvement component, taught specific prevention skills and knowledge, employed multiple prevention strategies, and continued for three to seven years.

Schools can include substance abuse prevention as part of a comprehensive integrated K–12 health education program.

The reason substance abuse belongs within the general health education program is that substance abuse behavior is ordinarily intertwined with other problem behaviors. School failure, dropping out, teen pregnancy, delinquency, and substance abuse are inclined to share a common etiology. According to Richard and Shirley Jessor, for both males and females, the association among these health compromising behaviors is "one of the clearest facts to have emerged from the past decade of prevention research."[15]

Schools can focus specifically on knowledge, attitudes, and behaviors that influence use of alcohol and drugs.

While substance abuse prevention should proceed within the context of health education, a specific focus on alcohol and drugs is indicated. If we expect to deflect actual substance abuse behavior, programs must begin building specific knowledge, positive attitudes, and useful skills about alcohol and drugs beginning by fourth grade.

Pertinent knowledge lies at the core of alcohol and drug prevention. It includes information about physiology, high-risk populations (especially genetic predisposition), high-risk situations (driving, pregnancy, stress, medication, and so on), actual prevalence, psychosocial correlates (like family influences, peer pressure, school failure, and stress), role of the media and cultural norms. Perhaps the most important information to convey, though, is knowledge that enables young people to estimate their personal risk for developing substance abuse problems.

We have learned the hard way that reliable information is necessary but not sufficient to affect actual substance use. Past programs have often assumed a causal relationship between knowledge and changes in attitudes and behaviors. This presumption has not been borne out, either by research or casual observation. Almost everyone, for example, accepts the evidence that ties smoking to nearly every health hazard from irritation to sudden death, yet many people continue to smoke.

Thus, Merita Thompson and coauthors concluded:

> To produce any persisting societal or personal effect requires both attitude change and action change. If a change produced is to be meaningful and stable, alcohol education must address knowledge, attitudes, and behaviors as a *focused set*–not independently.[16]

In the view of some analysts, past prevention efforts have erred in a second way that affects attitudes. Programs have supported the notion that people drink only because of personal weakness, emotional problems, or stress and have glossed over the reality that people often drink excessively in pursuit of pleasure or for social reasons. Thus alcohol education especially has failed to confront such common high-risk attitudes as "Drinking is a good way to have fun" and "Getting drunk for kicks is part of growing-up."

Part of Thompson's risk reduction model counters such expressions head-on with "Anyone could experience alcohol problems, and if I drink too much, I could, too" and "Whether or not I experience an alcohol problem is determined by if, how much, how often, and under what circumstances I choose to drink."[17]

Schools can develop programs based on a promising new approach, the social psychological model.

With social psychological prevention programs that strengthen resistance to peer pressure, several research groups have produced a *50 to 75 percent reduction* in the onset of smoking among adolescents. The same principles, researchers are finding, appear to work for delaying alcohol and marijuana use.

Johnson describes the common features of the social psychological tobacco prevention programs:

- a focus on short-term, primarily social consequences that are important to the target audience,
- audience sensitization to overt and covert pressures to smoke,
- attitudinal inoculation to those pressures,
- high levels of audience participation (including a Socratic approach to cognitive learning), and
- role-playing and other classroom exercises to practice behavior.[18]

An interesting and potentially critical factor in these programs is the importance of peer leaders. So far, long-term results have been documented only in those programs that trained either older "ideal" peer leaders or same-age "actual" peer leaders to assist in program implementation.

When Johnson and his colleagues at the University of Southern California's Health Behavior Research Institute extended this peer pressure resistance model to alcohol and marijuana use, they found significant reductions in the use of all three substances. They explain why they think that happened.

1. Research has found the same psychosocial correlates for tobacco, alcohol and marijuana.[19]
2. Research has also shown that the use of one of these substances predicts the use of the other two.[20]
3. The social resistance skills effective in avoiding cigarette smoking are applicable to alcohol and marijuana use.[21]

The institute's model is now being field-tested in sixth and seventh grades. Those age groups were selected because Johnson's research found that exposure before sixth grade was rare, but use of all three substances escalated rapidly during sixth and seventh grades.

Gilbert Botvin's Life Skills Training Program, developed at Cornell University, is another promising application of the social psychological model. It attempts to counter not only social pressure but life problems as well. While Botvin agrees

with Johnson that peer pressure is a strong influence on use of substances, he contends that "adolescent substance use/abuse is the result of the complex interplay of a diversity of factors." Drug use, he reasons, may not stem solely from peer pressure; it may serve a functional need such as a way of coping with social or academic anxiety. Still another variable, he wrote, is the person:

> Differential susceptibility to social influence (via media, parents, peers) appears to be mediated by personality, with individuals who have low self-esteem, low autonomy, low self-confidence and an external locus of control being more likely to succumb to these influences.[22]

Because Botvin sees a more complex set of causes for substance abuse, his program is more comprehensive than Johnson's. To specific tobacco, alcohol, and marijuana resistance skills training, the program adds development of general personal and social competence skills. He reports good results:

> In all of the studies conducted to date, this type of prevention program has produced significant changes on selected cognitive, attitudinal, and personality variables in a direction consistent with nonsubstance use.[23]

Schools can develop students' life skills.

Many researchers have concluded that programs must not only attend to specific alcohol and drug situations, but must build life skills in general. Such skills include:

- ***Communication.*** Sometimes called social skills or social competence, communication skills refer in a broad sense to how effectively a person can cope with interpersonal relationships. Programs to develop this capacity typically cover verbal and nonverbal communication, guidelines for avoiding misunderstandings with others, and heterosocial (boy-girl relationship) skills.

  Mary Ann Pentz's review of 117 social skills training studies found that over 93 percent of them reported total effectiveness–especially when they were conducted in school or community settings with normal (nontreatment) student populations.[24]

- ***General assertiveness.*** In the last decade, assertiveness training has been recognized in many prevention and intervention programs as an essential communication skill for building self-efficacy. The short-term outcomes of evaluated programs have been positive; long-term outcomes have been mixed. Botvin's successful Life Skills Training Program combines general assertiveness training with a specific focus on tobacco, alcohol, and drug assertiveness skills.

- ***Resistance skills.*** Teaching specific tobacco assertiveness (for example: "Just Say No!") has been a critical component in the successful social psychological smoking prevention model that is now being applied to alcohol and drugs. Such strategies are based on social inoculation theory, which assumes a person's resistance to social pressure is greater if the person has been "inoculated" by developing arguments in advance. Activities usually include forewarning, attitudinal inoculation, cognitive rehearsal (role playing), and a public commitment (behavioral contract to refrain from alcohol or drug use).

  Two cautionary points ought to be raised about teaching resistance skills. Such training usually urges a "No-Never" response, which, as O'Bryan points

out, does not prepare students for maturity. Students will reach the age of 21, after all, and by then other refusal responses like "No more" or "No, not today" may become appropriate.[25]

Often overlooked also is the possibility that many children may not want to refuse, and why they don't is still a mystery.

According to Botvin:

> While high correlations have been found consistently between individuals' substance use and that of their friends, it is unclear to what extent these associations are the result of peer pressure rather than a process of mutual self-selection.[26]

- ***Peer selection.*** Because of Botvin's rationale, some recent research has identified peer selection as a skill that may be even more valuable than refusal (resistance) skills.
- ***Problem solving and decision making.*** A substantial body of longitudinal research implies that explicit early instruction in social problem solving averts subsequent problem behaviors. Kellam's Woodlawn study, for instance, found that antisocial first graders were significantly more likely to be involved in substance abuse and delinquency ten years later. Rutter's research on five-year-old girls institutionalized because of severe abuse or neglect found that the ones who were able to plan and solve problems overcame their early trauma and were leading productive lives 14 years later. One commentator identified problem-solving/planning skills as the critical component of the successful Perry Preschool Project curriculum. Similarly, George Spivack and Myrna Shure's research on Interpersonal Cognitive Problem Solving (ICPS) documented significantly fewer behavioral and academic problems among children in kindergarten through second grade if they had experienced ICPS as preschoolers.

  The hypothesized process is that problem-solving skills contribute to the development of an internal locus of control. That in turn builds a sense of self-efficacy and self-esteem, which ultimately strengthens resistance to substance abuse, among other problem behaviors.
- ***Critical thinking.*** Critical thinking, defined as problem solving applied to specific subject matter, forms a bridge over the chasm that divides the affective and cognitive domains of learning. A goal of critical thinking development justifies the school in going beyond the confines of a back-to-basics-only approach.
- ***Making low-risk choices.*** Two life-style risk reduction programs developed by the Kentucky Prevention Research Institute received positive preliminary evaluations. Talking to Your Kids about Alcohol and Talking to Your Students about Alcohol delineate five skills that are necessary to make a low-risk choice about alcohol. An individual should:
  1. understand that the primary determinant of alcohol problems is Alcohol/Quantity/Frequency (A/Q/F),
  2. have skills needed to estimate one's personal risk of developing alcohol-related problems and to identify specific low-risk choices,
  3. have skills to identify and evaluate one's own attitudes, values and expectations that support low-risk choices,

4. have skills to identify and evaluate the beliefs, values, and customs of family, associates, and culture that support both low- or high-risk choices, and
5. have skills needed to adopt and maintain low-risk choices.

- ***Self-improvement.*** Part of Botvin's Life Skills Training Program is experience in designing and implementing a self-improvement project. Students identify a skill or behavior that they would like to change. They set long-term goals (eight weeks away) and short-term objectives (one per week) to meet that goal. This process is thought to foster self-efficacy and an internal locus of control.
- ***Stress reduction skills.*** A growing body of research has found stress to be significant contributor to adolescent substance abuse,[27] and the problem seems to be intensifying, Director Lloyd Johnston found in the National Institute of Drug Abuse's annual high school survey that the number of high school seniors who reported drinking "to get away from my problems" rose by half between 1975 and 1984, leaping from 12 to 18 percent. Those who said they drank to "deal with anger and frustration" rose from 11 to 16 percent. Johnston warned, "The kids in danger of getting into a chronic state of alcoholism are the ones using alcohol to help them cope in their day-to-day lives."[28]

- ***Consumer awareness.*** Being able to analyze and evaluate media messages, especially advertising, is increasingly regarded as an important element of prevention programming. Youth need to know the techniques of attitude manipulation if they are to resist the powerful bombardment of pro-use messages.

Building life skills makes strong demands for good instruction. Numerous experiential activities (such as role playing and values identification, problem solving, and goal setting) should include both a general and a specific alcohol/drug focus. Dynamic activities and support materials should be directly relevant to issues and people of interest to youth. Instruction should accommodate different learning styles (visual, auditory, and kinesthetic) and relate to the ethnic composition of the school. One addition that is not common to ordinary instruction, though, is the necessity of parent involvement.

SPECIFICS SCHOOLS CAN ACCOMPLISH NOW: GROUP I

One set of activities for schools concerns efforts that take place within school systems. A second set relates school systems to other social systems. In the first group:

School programs can combine prevention efforts directed at tobacco, alcohol, and marijuana.

The data from the smoking prevention programs support a three-pronged focus on all of the so-called gateway drugs: tobacco, alcohol, and marijuana. All three tridents are thought to precede the use of hard drugs, such as cocaine.[29] Though data have shown some spontaneous spill-over effects from smoking prevention to alcohol and marijuana use, it is doubtful that the benefits are strong enough to be sustained without further attention. A substance abuse curriculum should therefore focus on knowledge, attitudes and skills specific to each of these substances.

School programs can create a hospitable climate for psychological health.

This principle fans out into several initiatives:

- ***Promote students' self-esteem.*** Andre Olton, among others, has stressed the importance of a humane school climate in the battle against substance abuse. He wrote, "Students may be more receptive to efforts at substance abuse prevention if these efforts originate in an organization which they believe respects, appreciates, and cares about them."[30]

  A large segment of research has centered on identifying positive family and school environments. A review of both locuses favors environments that provide all children with opportunities to participate and expectations that they will shoulder some responsibilities. Michael Rutter's research on schools, for example, identified these two variables as crucial in preventing school failure and delinquency. School effectiveness research and studies on the Pygmalian effect (the self-fulfilling prophecy) also support these dual goals.

  Another crucial component in nurturing self-esteem is the attitude of teachers toward students. While some researchers (Johnson) have found only prevention programs that use peer leaders to be effective, others (Thompson, Botvin, and Kellam) have found programs effective *if* the teachers viewed students as worthwhile. If lack of self-esteem is a strong correlate of substance abuse–and many researchers have found that it is–school activities need to seize every opportunity to build and reinforce students' sense of self-worth. Failure to do this, according to Yale child psychiatrist James Comer, results in the following sequence:

  > When a school staff (especially in the elementary grades) fails to permit positive attachment and identification, attachment and identification take place in a negative way. The school becomes the target of a child's angry feelings with resultant rebellion, ambivalence, and apathy. The school is then unable to interrupt troublesome development or compensate for underdevelopment. The performance of such children falls farther behind their potential as they progress through school, and the skills needed for future school success are not gained.[31]

- ***Promote academic success.*** Academic success is an integral component of self-esteem. Sheppard Kellam conducted the first major long-term study of

first-grade behavior and development and later psychological and social-adaptational adjustment in the teenage years. He found that first-graders who failed to learn, who rebelled against the rules and authority of the school, and who were socially isolated in the classroom were, ten years later, the youth involved in substance abuse, delinquency, dropping out, and other problem behaviors.

In *Prevention Research on Early Risk Behaviors*, a paper prepared for an international conference on environment, mental health, and early brain development, Kellam explained what is and is not clear about the relationship of learning problems and substance abuse:

> First grade problems in learning . . . are a strong and specific predictor of teenage depressive and other [psychiatric] symptoms among males and to a lesser extent among females.
>
> First-grade aggressiveness without shyness in males (not females) is a strong predictor of increased teenage delinquency (and drug, alcohol, and cigarette use) . . . A combination of shyness and aggressiveness in first-grade males (not females) was associated with higher levels of delinquency and substance use than aggressiveness alone.[32]

Hence, early learning problems predispose children to later psychiatric distress, while aggression, particularly with shyness, is linked to later substance abuse. What is still not clear, Kellam continued is "whether shy and/or aggressive behavior stems from the experience of failure or is a predisposition of the child . . . regardless of academic success or failure."[33]

In cooperation with 19 Baltimore City schools, Kellam and his associates are now in the second year of a ten-year longitudinal study of this relationship. The project is tracking the effects of improving mastery of core skills, especially reading, and reducing shy and aggressive behavior. The effort trains teachers to provide, first, a mastery learning program in reading, writing, and arithmetic; it emphasizes group and individual instruction, defines clear goals for students, and gives them the time and assistance to reach those goals. A second part of the project integrates classroom management strategies that reward social participation and obedience to classroom rules.

Until we understand how learning problems contribute to the early shy and aggressive behavior that predicts later drug abuse, it makes sense to hypothesize a causative relationship and concentrate on ensuring early academic success. As Kellam reasons:

> Every child has to feel some sense of integrity as a person, and [they] either do that by learning to read and succeeding in the mainstream, or by getting a sense of who [they] are in another way–either through withdrawing, or through aggression and antisocial behavior, or through psychiatric distress and mental disorder.[34]

- ***Provide the opportunity for critical thinking and problem solving.*** A positive school and classroom climate that encourages discussion of social values, ethics, and moral dilemmas–and thus engages critical thinking and problem solving–also facilitates prevention programming. Many educators caution that the current push for a basics-only curriculum, which emphasizes rote and solitary learning, discourages such discussion. As Francis Robert commented in *Parents*:

> It is essential that children talk together about new learning, responding in their own words, not simply listening to teacher abstractions and then being

assigned workbook pages with short, blank spaces to fill in . . . The teachers [must capture] every opportunity to foster intellectual mastery and to promote cognitive power by creating a pervasive climate of why and wherefore and wherefrom kind of thinking.[35]

- ***Extend problem solving and planning into expanded preschool services.*** Two years ago, the results of a 15-year early childhood intervention study added persuasive, dollars-and-cents reasons for schools to expand their services to three- and four-year-olds. The results from the Perry Preschool Project of the High/Scope Educational Research Foundation in Ypsilanti, Michigan, provided solid evidence that early preventive interventions can significantly alter subsequent child development.

  The Perry study shows that, by age 19, young people who had attended a preschool program at age 4 had fewer negative and more positive characteristics. They were significantly less likely to have learning problems, or histories of dropping out of school, delinquency, and teen pregnancy. They were more likely to be employed and had almost twice the post-high school education incidence as did the comparison group.

  The children in the Perry Preschool Project all came from a low socio-economic, black, urban environment; half of them lived in single-parent families. At either age three or four, they attended preschool for 2½ hours each morning. The intent of the program was the development of cognition, language, information and experience, and social and behavioral skills necessary for school adjustment. Along with active learning, problem solving, and planning, the program emphasized a high degree of interaction among adults and children, among the children themselves, and among parents and teachers. A *Wall Street Journal* review described Perry Preschool business as usual:

  > The program involved no set curriculum and could be duplicated with $100 or so of materials. At the beginning of each day the children were asked to plan their "work" for the morning. Rather than telling the children what do do, the teachers would ask each child to make an estimate of what he/she could accomplish that day and to take responsibility for carrying out whatever he/she decided. Gradually, *the children came to see themselves as planners–as people who had some power over their lives, not as passive victims.*[36]

  These data have major implications for substance abuse prevention. The results of a 1986 High/Scope curriculum comparison study included drug use

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as a variable. It found that children who had experienced one year of preschool at age 4 were half as involved in drug use and delinquency at age 15, if and only if the program encouraged the active involvement of students in planning their activities. The teacher-controlled preschool program had no such outcomes.

- ***Train teachers thoroughly.*** Special attention to teacher preparation is vital to correct the omissions that have substantially weakened previous prevention. As Peter Finn notes, "Because alcohol education deals with strongly held values and feelings, and because its ultimate goal is to fashion or change attitudes and behavior, instructors need special skills to be able to teach effectively in this field."[37]
- ***Create positive alternatives.*** Another prevention step schools can take is to develop alternative activities that bring all youth into contact with positive peer role models and caring adults from the community. Traditional school-sponsored activities like clubs, athletics, and student government most often serve academically and socially successful youth, thus reinforcing support and school involvement where it already exists in the greatest degree.

  Nonparticipants, Polk wrote, neither have nor get: "Isolated from both successful peers and legitimate adults, marginal young persons have few choices to run to for social contact, support, and fun other than their marginal peers."[38] The absence of social alternatives becomes especially serious when considered alongside research findings that identify substance use of close peers as the most powerful factor influencing youthful use of tobacco, alcohol and marijuana.

Not only, as Johnson found, are peer leaders more effective at dissuading others from using alcohol, tobacco, and marijuana, but the needs for youth involvement and positive role models are served by positive peer programs. Such programs as peer counseling, peer and cross-age tutoring, and peer teaching of alcohol and drug information encourage sound self-esteem, mature problem solving, and effective decision-making skills in young leaders. Ardyth Norem-Hebeisen and coauthors add that peer involvement also provides "participating youth with meaningful roles and real-world responsibilities at a time when youth are increasingly isolated from such roles and responsibilities in the prolonged adolescence characteristics of our culture."[39]

We ought not undervalue the importance of such connectedness in countering alienation and the problem behaviors that grow in its valueless void. If we do, Saul Levine comments on the penalty:

> Unless a social system–be it a family, group (school), neighborhood, or society–can instill in its youth some degree of purpose and community, a substantial proportion of the adolescents, particularly those with low self-esteem and increased vulnerability, inevitably will become society's problems.[40]

SPECIFICS SCHOOLS CAN ACCOMPLISH NOW: GROUP II

School programs cannot succeed if they operate out of sync or at cross purposes with all other influences in the lives of youth. A second set of school activities, therefore, relates schools to other social systems:

Schools can establish clear, firm policies.

We are beginning to see indications of "significantly fewer infractions" in schools that have set policies prohibiting the use, possession, or sale of illegal substances; that have communicated those policies to students, parents, faculty, and staff; and that have equitably and consistently enforced those policies.

Schools can collaborate with students, teachers, media, community, and especially with parents.

The importance of collaboration in setting policy and in the planning, implementation, and activities of a comprehensive health education curriculum can hardly be overemphasized. The involvement of all key players not only breaks down the isolation of a lone, school-based program; it also creates a broad sense of ownership and commitment that makes reinforcement of prevention messages more likely outside the classroom.

Parents should not only be involved in substance abuse policy and curriculum development, but should be encouraged to collaborate with teachers, take part in parent education and support programs, and volunteer as aides or resources. Comer believes the estrangement of parents from schools has been particularly serious for children in families under stress, but he also sees this bad situation as reversible. "Parent presence in responsible and respected roles in the school," he said, "sends a message to the children: The school people and program are important."[41]

Comer's Yale Child Study Center model for school improvement has focused on developing parental involvement as a strategy for reducing the "negative impact of change, social stratification, conflict and distrust between home and school."[42] Similarly, the "school-team" approach advocated by the U.S. Department of Education's Alcohol and Drug Abuse Education Program includes parents, teachers, administrators, students, and school board members in substance abuse prevention programming.

Schools can collaborate with research and evaluation efforts.

For too long, substance abuse research has been the domain of health professionals, and prevention programs the territory of the schools. Effective future programming will require closer cooperation between these two systems.

We have discussed the positive outcomes that researchers like Johnson, Botvin, Weikart (of High/Scope), and Kellam have achieved and the useful, *transferable* principles their efforts suggest to program planners. The critical issue now is how best to replicate these programs in field settings with diverse populations.

Appropriate programs will require the kind of active collaboration between researchers and schools we now see with Johnson's group in Los Angeles and Kellam's in Baltimore.

The challenge for researchers is to codify their findings in accessible forms. As one researcher warned, "If prevention research is to have a significant impact . . . researchers must soon face the challenge of packaging effective interventions in feasible forms that can be easily and correctly administered in diverse locales by people with different educational backgrounds and a variety of training experiences."[43] The challenge for schools is the need to make long-term commitments to collaboration and the discovery of what-works principles.

EXPECTING THE POSSIBLE

Despite past disappointments with isolated, fragmented programs that expected too much, the behavior changes that some social psychological programs have documented suggest that delayed onset and reduced incidence of substance use may actually be valid program goals.

Because of the many mediating variables in changing substance use behavior, however, several researchers urge restraint in developing program goals. Ends, they think, should be sufficiently concrete and specific as to be measurable and realistic and attainable enough to produce some immediate gains. Goodstadt elaborates:

> A more balanced view of the potential impact of drug education would reduce expectations to fit the realities of competing forces and the importance of time and normal development. Programs would not be expected to produce immediate large shifts in behavior; at best they would result in statistically significant changes in indicators of future behavior, including measures of current attitudes, expectations, and behavioral tendencies.[44] [Editor's Note: For a discussion of indicators of future behavior, see Appendix A–"Risk Factors for Adolescent Substance Abuse."]

Thompson and associates refer to Goodstadt's "more balanced view" as "lifestyle risk education."

> In a democratic society of which alcohol is a part, the only realistic practical hope is that people will make choices about alcohol consumption that reduce their risk of alcohol-related problems. Alcohol education efforts should be focused on enabling people to adopt and maintain low-risk choices.[45]

Weisheit recommends acknowledgment of alternative views of success, too, reasoning that prevention programs have beneficial effects other than changes in student knowledge, attitudes and skills. "A number of valid definitions of success exist, and a thorough evaluation cannot afford to focus on only one,"[46] he emphasizes, citing the worth of process objectives like increased parent and community involvement in the schools and increased intensity of student-teacher interaction.

NO SILVER BULLET

What we now know about substance use and abuse gives us no "silver bullet" or "quick fix" to guide schools in prevention efforts. On the contrary, we can see that the job requires schools to make a commitment to long-term, comprehensive prevention efforts and to active collaboration with other involved systems.

The need for schools to make these twin commitments is apparent and increasingly compelling. In the past two years, numerous reports from the fields of education, business, mental health, and social services have documented that, in Mark Testa's words, "the collective condition of all sectors of children and youth in our society has worsened."[47]

A basic problem reiterated in these reports is a rapidly increasing population of youth primed for educational failure, and as a consequence, set up for adult unemployability and social incompetence. In 1985, Henry Levin, for instance, counted *30 percent* of school-age children in the U.S. as living in environments characterized by poverty, ethnicity, and parents who are often single, illiterate, and unemployed.[48]

Clearly, the number of children at risk for living and perpetuating a vicious cycle of deprivation and stress associated with social ills like child abuse, domestic violence, crime, and substance abuse has reached a crisis level and shows every indication of getting worse in the future.

As futurist statistician Harold Hodgkinson has frequently pointed out, the cost of these individual failures becomes a great collective burden on society because unemployable citizens drain resources without returning much in taxable income. At a November 1986 conference on the future of science, Hodgkinson recalled that 17 people used to support every Social Security recipient, but in the near future, only 3 will do so, and 1 out of 3 will be a minority. "We've got to be sure," he vowed drily, "that every minority student gets a good education and a *splendid* job."

Responsibility for improving the lot of children rests not only with the schools but with parents, students, individual schools and preschools, local communities, professional organizations, social service and mental health professionals, higher education institutions, commercial enterprises, policymakers at every level, and the media. Effective reform can only result from active collaboration among all these groups.

To link the institutions that develop children into productive adults, society needs something it does not now have: a structure for interdisciplinary long-range youth advocacy planning. The extent of need for such coordination is exceeded only by its degree of scarcity. We at the Prevention Resource Center,* for example, are surprised to find ourselves a solitary model of state effort to provide prevention training, resource materials, and technical assistance.

The recent flurry of reports that call for attention to the development of youth evoke a sense of eleventh-hour crisis. "As with all social investments," Levin warned, "time is of the essence. [Prevention] requires a considerable gestation period before its payoffs are evident. We must move with a great sense of urgency if we are to avert the costly consequences of our past inaction."[49] The number of at-risk youth, Hodgkinson added, is "now so large that if they do not succeed, all of us will have diminished futures. That is the new reality."[50]

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